PROMISING PRACTICES IN HOME AND COMMUNITY-BASED SERVICES

Vermont – Facilitating Nursing Home to Community Transitions

Issue: Diverting Nursing Facility Dollars for Community-Based Options

Summary

The State of Vermont's legislature required reductions in nursing facility utilization and increases in home and community-based services (HCBS) in 1996. The State implemented several changes to meet this mandate, including: a change in the waiting list policy for Vermont's largest Medicaid HCBS waiver for older people and people with physical disabilities, the creation of a statewide system of local Long-Term Care Community Coalitions to improve the HCBS infrastructure, and a new Medicaid HCBS waiver for community residential options. As a result, between 1996 and 2004, the share of Vermont's long-term care expenditures for older people and people with physical disabilities spent on care in nursing facilities decreased from 88 percent to 70 percent.

Introduction

Vermont passed landmark legislation in 1996 to shift resources from nursing facilities to a broad array of home and community-based services (HCBS). To implement the legislation, called Act 160, the Department of Aging and Independent Living – DAIL (formerly the Department of Aging and Disabilities) implemented several programs, new services, and policy changes that offered individuals more choices for long-term services. As more people chose to receive services outside of nursing facilities, more funding was made available for programs that promoted independent living opportunities for older people and people with disabilities.

This report briefly describes how the State of Vermont changed its long-term care system to reduce institutional reliance by supporting people with physical disabilities and older people in the most appropriate and least restrictive environment possible. All information is based on interviews with DAIL staff and publicly available materials from the DAIL web site (http://www.dad.state.vt.us).

Intervention

Vermont's legislature identified four primary goals for Act 160: 1) to improve the state's independent living options for older people and people with physical disabilities; 2) to create a climate where Vermonters may live in the most independent, least restrictive environments they choose; 3) to decrease the growth of the Medicaid nursing facility budget through the development of consumer options; and 4) to redirect nursing facility dollars into HCBS with consumer participation and oversight in the planning and delivery of long-term care services.

Vermont's initiatives to achieve these goals include: the establishment of Long-Term Care Community Coalitions, a change in prioritization for Medicaid HCBS waivers for older people and people with physical disabilities, and a new Medicaid HCBS waiver called the Enhanced Residential Care Program.

Long-Term Care Community Coalitions

On July 1, 1996 the Vermont Legislature authorized an additional source of funding to expand and develop services for older people and people with physical disabilities who want to continue to live at home, but need help in order to do so. As part of Act 160, the state mandated the implementation of "a system of statewide long-term care service coordination and case management to minimize administrative costs, improve access to services and minimize obstacles to the delivery of long-term care services to people in need."

As a result of this charge, DAIL brought together providers of long term supports – including representatives from Area Agencies on Aging (AAAs), home health agencies, adult day centers, nursing facilities, hospitals and

residential care homes – to organize ten Long-Term Care Community Coalitions across Vermont. The coalitions – whose members include advocates and consumers as well as providers – assume responsibility for the planning and coordination of their local long-term care systems. Coalitions meet on a regular basis, coordinate services, determine unmet needs and seek ways to improve the service capacity in their areas.

A primary component of the coalitions' work was to implement innovative strategies designed to reduce unnecessary nursing facility and hospital emergency room utilization. DAIL also asked the coalitions to help the Department find ways to expand and develop new services, using the savings generated under Act 160. To date, the coalitions have focused on the development of volunteer caregiver registries, training personal care attendants, supporting the expansion of adult day programs, expanding home-delivered meal capacity, and educating physicians and the public about various long-term care options.

As of November 2004, the state distributed $90,000 annually in flexible funds to the coalitions to purchase services and items for individuals for which no other sources of funds can be found.

Waiver Prioritization
In November of 1996, DAIL revised its admission procedures to the Medicaid Home and Community-Based waiver program and began to admit people based on need instead of their date of application. The waiver prioritization policy gives priority access to Medicaid HCBS waiver services to four applicant groups: 1) applicants who are in a nursing facility and wish to be discharged to a community setting but cannot do so unless waiver services are provided, 2) applicants who are in a hospital, wish to be discharged to a community setting, and who would be admitted to a nursing facility unless waiver services are provided, 3) applicants in the community at risk of significant harm unless waiver services are provided, and 4) applicants at risk of moving to a more restrictive setting unless waiver services are provided.

At the same time, DAIL established regional Designated Administrative Agencies to oversee the prioritization process. Ten local, private, non-profit Designated Administrative Agencies -- either local home health agencies or AAAs – administer Vermont's Medicaid HCBS waivers for older people and people with physical disabilities at the local level. Local Medicaid HCBS waiver teams, which include local case managers from these agencies and staff from other local HCBS agencies, assess waiver applicants and determine whether applicants fall into one of the four priority groups.

DAIL reviews waiver enrollment monthly and allocates waiver resources to local Designated Administrative Agencies to ensure that priority applicants have consistent access to waiver services. Currently, priority applicants usually are able to access waiver services within 60 days, and often much faster.

Enhanced Residential Care Program
DAIL also established a new waiver, the Enhanced Residential Care Waiver (ERC), to offer a Medicaid-funded residential option. ERC provides 24-hour care at a licensed Residential Care Home, to delay or prevent nursing facility admission. Services available to ERC waiver participants include: case management by the local AAA or home health agency; nursing services (assessment, health monitoring, and routine nursing care provided or supervised by a licensed registered nurse); personal care services; medication assistance; recreational and social activities; support for older people with Alzheimer's Disease or other dementia-related illnesses; 24-hour on-site supervision; and laundry and household services.

Implementation

Although many of the above changes can be implemented in other states, state staff identified a few advantages Vermont had during implementation. One advantage was Vermont's small size in terms of geography and population. Vermont was able to create a small number of Long-Term Care Community Coalitions (ten) in which the providers, advocates, and consumers knew many of the other people involved in the long-term care system.

While implementing Act 160, Vermont changed Medicaid nursing facility reimbursement to pay nursing facilities based solely on the case-mix of

their facilities' Medicaid population rather than on their total resident population. According to state staff, this change gave nursing facilities an incentive to focus on people who need rehabilitation or who have the most severe disabilities, and an incentive to support people with less severe disabilities if they want to move into the community.

Impact

Since Act 160 was enacted, Vermont has witnessed a drop in nursing facility utilization and an increase in the utilization of waivers. Nursing facility occupancy is approximately 93%, compared to a historical peak of 98%. In 1996 there were 3,788 beds, which decreased to 3,419 beds in 2004. It is important to note that these declines in occupancy rates occurred within the context of rising HCBS utilization and declining nursing facility utilization. These recent trends have prompted several nursing facilities to downsize or close, affecting nursing facility occupancy rates due to a tighter bed supply.

Between state fiscal years 1996 and 2004, the share of Vermont's long-term care expenditures spent on HCBS for older people and people with physical disabilities increased from 12 percent to 30 percent. Between 1996 and 2004, total public expenditures for DAIL's Medicaid HCBS waivers increased more than four-fold and the number of people served almost doubled. Vermont currently serves 1,350 people per year through Medicaid HCBS waivers for older people and people with physical disabilities. The original waiver, which serves people in their own homes, serves 1,200 people per year and the Enhanced Residential Care waiver serves approximately 150 people per year.

Contact Information

For more information about the changes in Vermont's long-term care system for older people and people with physical disabilities, please contact Joan Senecal, Principal Assistant to the Commissioner (802) 241-2326 or joans@dad.state.vt.us. Online information about Act 160 and the state's long-term care system is available at http://www.dad.state.vt.us.

Discussion Question:

How could states adapt the Long-Term Care Coalitions to a large metropolitan area with many home health agencies and other community providers?

The original report was written by Amy Leventhal Stern, Ph.D. The MEDSTAT Group revised the report, one of a series of reports by The MEDSTAT Group for the U.S. Centers for Medicare & Medicaid Services (CMS) highlighting promising practices in home and community-based services. The entire series is available online at CMS' web site, http://www.cms.hhs.gov/promisingpractices. This report is intended to share information about different approaches to offering home and community-based services. This report is not an endorsement of any practice.